

# How should Australia respond to media-publicised developments on euthanasia in Belgium?<sup>1</sup>

## Abstract

*This article considers what implications recent euthanasia developments in Belgium might have for the Australian debate on assisted dying. Through media database and internet searches, we identified the cases of three individuals that have been the subject of considerable media attention as well as recent legislative changes that allow children access to euthanasia. The article outlines these developments and then examines how they have been discussed in Australia by the different sides of the euthanasia debate. We conclude that these developments are important considerations that legislators and policy-makers in Australia should engage with but argue that that engagement must be rational and also informed by the significant evidence base that is now available on how the Belgian (and other) assisted dying regimes operate in practice.*

## 1. Introduction

Euthanasia is the subject of global debate and this is reflected in ongoing popular media coverage and discussion. The Australian media have taken a keen interest in developments in the assisted dying area both locally and internationally.<sup>2</sup> This perhaps reflects the widespread interest in this issue in the community. Regular polls conducted across the country demonstrate strong and, over a period of time, growing community support for changes to the law.<sup>3</sup> The increasing public and political support for

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<sup>1</sup> Dr Neera Bhatia, Senior Lecturer, Faculty of Law, Deakin University; Professor Ben White, Director, Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology (QUT); Professor Luc Deliens, Professor of Palliative Care Research, Director, End-of-Life Care Research Group, Ghent University and Free University Brussels (VUB), Belgium. The authors are grateful for the research assistance of Helen Wood, Professor Danuta Mendelson and William Isdale.

<sup>2</sup> See for example, ABC Radio National Breakfast, 'Euthanasia specialist Rob Jonquiere on the implementation of assisted dying in the Netherlands' (1 June 2015) <<http://www.abc.net.au/radionational/programs/breakfast/euthanasia-specialist-rob-jonquiere-on/6510854>>; Benjamin Jones, 'Singer and Fisher preach to their flocks in euthanasia debate', The Conversation (14 August 2015) <<https://theconversation.com/singer-and-fisher-preach-to-their-flocks-in-euthanasia-debate-45880>>; Rosemary Bolger, 'Voluntary euthanasia bill may be delayed to secure support from Liberal MP, Giddings says', ABC News (26 August 2015) <<http://www.abc.net.au/news/2015-08-26/voluntary-euthanasia-bill-may-be-delayed/6725084>>; David Swanton, 'Voluntary euthanasia is about choice and respect', The Sydney Morning Herald (7 June 2015) <<http://www.smh.com.au/comment/voluntary-euthanasia-is-about-choice-and-respect-20150605-ghhhy4.html>>; Charles Lane, 'Euthanasia's slippery slope', The Age (20 August 2015) <<http://www.theage.com.au/comment/euthanasias-slippery-slope-20150820-gj3xeo.html>>.

<sup>3</sup> For example, the 2015 vote compass survey found that 72 % of New South Wales voters, 75.9% of Queensland voters were in favour of physician assisted dying. Claire Aird, *NSW election 2015: Almost three quarters of voters support euthanasia, Vote Compass finds* (15 March 2015) ABC News <<http://www.abc.net.au/news/2015-03-15/nsw-voters-support-euthanasia-vote-compass-finds/6313864>>; Matt Wordsworth, *Vote Compass: Majority of Queenslanders in support of euthanasia* (28 January 2015) ABC News, <<http://www.abc.net.au/news/2015-01-28/vote-compass-majority-of-queenslanders-in-support-of-euthanasia/6049750>>.

euthanasia is also evident in the formation of the Voluntary Euthanasia Party, which has a presence federally as well as in New South Wales and Victoria.<sup>4</sup>

This article considers a particular aspect of these public debates: the recent developments in Belgium that have become focal points for media coverage of the assisted dying debate. Since 2012, there have been cases involving three individuals seeking assistance to die and one instance of legislative reform (to allow children access to euthanasia) that have received extensive media discussion in Australia and internationally. These ‘Belgian developments’ (discussed below) were identified through searches of media databases.

The article begins by outlining the regulatory framework that governs euthanasia in Belgium. We then analyse the four Belgian developments drawing on media reports and other publicly available resources to try and provide a platform for informed discussion. We note that at least some media reports have not provided sufficient information to understand properly the nature of the issues being discussed. The article then considers how these developments have been used in the public (and sometimes academic) discourse on assisted dying reform in Australia. We critically examine these arguments, including by having regard to the publicly available evidence about how the regime is operating in Belgium. The article concludes with some observations about the appropriate relevance of the Belgian developments for the assisted dying debate in Australia.

## 2. An Overview of the Belgian Act on Euthanasia 2002

On 23 September 2002 the Belgian Act on Euthanasia came into force,<sup>5</sup> making it the second Benelux country, after the Netherlands, to permit euthanasia provided certain conditions are met.<sup>6</sup> The Act defines euthanasia as ‘intentionally terminating life by someone other than the person concerned, at the latter’s request’.<sup>7</sup> While the law does not expressly permit assisted suicide, the practice does occur and is

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<sup>4</sup> Ross Fitzgerald, ‘Growing numbers demand right to die, a call that can’t be ignored’, *The Australian* (Online), 14 March 2015, <<http://www.theaustralian.com.au/opinion/columnists/growing-numbers-demand-right-to-die-a-call-that-cant-be-ignored/story-e6frg7eo-1227261950803>>. See also, Voluntary Euthanasia Party <<http://www.vep.org.au/>>.

<sup>5</sup> Hereinafter all references to the Belgian *Act on Euthanasia 2002* will be referred to as ‘The Act’. All citations are from the English translation of the Act provided by Dale Kidd under the supervision of Professor Herman Nys from the Centre of Biomedical Ethics and Law, University of Leuven, Belgium in, *Ethical Perspectives* (2002) 9 182-188 <<http://www.ethical-perspectives.be/viewpic.php?TABLE=EP&ID=59>>.

<sup>6</sup> Luxemburg became the third Benelux country to permit euthanasia in 2009. A comparative table of the legislation in these three jurisdictions (as well as Australia’s Northern Territory, and Oregon and Washington) is available in Ben White and Lindy Willmott, ‘How should Australia regulate voluntary euthanasia and assisted suicide?’ (2012) 20 *Journal of Law and Medicine* 410, Appendix. Note also that Belgian Bills on palliative care and patient’s rights were heard and passed as laws at the same time as their euthanasia law.

<sup>7</sup> Section 2.

reported to the Federal Control and Evaluation Commission (FCEC) as such.<sup>8</sup> The Belgian Act allows euthanasia under strict conditions which this article now turns to discuss.

### *The patient's age*

Section 3 (Article 1) of the Act states that a physician does not commit a criminal offence when performing euthanasia where specific conditions are met. One condition is that the patient must be an adult (18 years or older) or is an emancipated minor.<sup>9</sup> This latter group is generally deemed to be minors between the age range of 12-18 years who have a reasonable understanding of their own interests and make a legitimate request for euthanasia. In 2014, the Belgian Act on Euthanasia was extended to children of any age provided certain strict conditions were met. This extension was accompanied by media controversy<sup>10</sup> and will be discussed further in section 3 of the article.

### *The patient's condition*

Section 3 (Article 1) requires that the patient requesting euthanasia must be in 'a medically futile condition of constant and unbearable physical or mental suffering that cannot be alleviated, resulting from a serious and incurable disorder caused by illness or accident.' This requirement contains two criteria. One is objective and obliges the physician to assess whether in fact the patient has a serious and incurable disorder. This assessment is based on clinical evidence and is subject to review by one or more independent physicians as discussed below. The second criteria relates to the whether the suffering is 'constant and unbearable' and 'cannot be alleviated'. This is subjective and is assessed from the patient's perspective although there is a requirement that the physician must have several conversations with the patient about this and be certain that the suffering is constant and unbearable.<sup>11</sup>

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<sup>8</sup> The few cases of assisted suicide that are reported to the FCEC are only those that are fully medically assisted, that is, the physician assessed all legal criteria and took full responsibility even though it was the patient who actually administered the lethal drugs. Burkhardt et al suggest that one reason for the exclusion of assisted suicide from the Act may be due to the cultural and social taboo associated with suicide in Belgium. See further, S Burkhardt et al, 'Euthanasia and Assisted Suicide: Comparison of Legal aspects in Switzerland and other countries' (2006) 46 (4) *Medicine, Science and the Law* 287, 291. See also, S Burkhardt et al, 'Euthanasia and Assisted Suicide: Comparison of Legal aspects in Switzerland and other countries' (2006) 46 (4) *Medicine, Science and the Law*, 287, 291.

<sup>9</sup> Walter De Bondt notes that an earlier proposal for the Act on Euthanasia did contain a change to the penal code, it stated, 'provisions concerning murder were not applicable, when the conditions of the Act were observed'. However due to the objections of some senators that the rule 'thou shalt not kill' should not be subject to any exception, it was decided not to change the penal code. See further, Walter De Bondt, 'The New Belgian Legislation on Euthanasia' (2003) 8 *International Trade and Business Law Review* <http://www.austlii.edu.au/au/journals/IntTBLawRw/2003/12.html>. For a more detailed discussion about the Belgian Penal code, see generally, Jos Monballyu, *Six Centuries of Criminal Law: History of Criminal law in the southern Netherlands and Belgium* (Koninklijke Brill, 2014) 32-33.

<sup>10</sup> Aileen Phillips, *Controversy as Belgium approves child euthanasia* (17 February 2014) SBS <<http://www.sbs.com.au/news/article/2014/02/17/controversy-belgium-approves-child-euthanasia>>.

<sup>11</sup> Tinne Smets et al, 'Legal Euthanasia in Belgium: Characteristics of all reported euthanasia cases' (2009) 47 (12) *Medical Care* 1, 1. Smets et al, conducted a study on the characteristics of patients requesting euthanasia in Belgium between 2002-2007 and noted that the nature of psychological suffering included depression and psychosis.

Of note for this article, given the three cases discussed in the next section, is the suffering criterion and in particular, that mental suffering is sufficient to access the Belgian system. This is, of course, provided that mental suffering is constant and unbearable as noted above and also that the objective criterion of serious and incurable disorder is also met. Approximately 3.5% of all reported euthanasia cases in 2011 were based solely on the mental suffering aspect of the subjective criterion,<sup>12</sup> although we note that suffering at the end of life generally involves both physical and mental aspects.

Section 3 (Article 1) also requires that the patient's request for euthanasia be voluntary, well considered, repeated, and made without any external pressure. The patient must also be conscious and legally competent at the time that the request is made.

#### *Patient's request must be durable*

The Act does not stipulate that the patient must be a Belgian citizen or resident, although we note that the patient's request must be 'durable' and that the legislation states that this assessment means that the physician must have 'several conversations with the patient spread out over a reasonable period of time'. It may be difficult to satisfy these requirements where the person is not ordinarily living in Belgium.

#### *Request must be in writing*

Under section 3 (Article 4) of the Act, the request for euthanasia must be in writing and signed by the patient. Where a patient is incapable of doing so, a designated representative for the patient, who is an adult with no material interest in the patient's death, may draw up the document and sign it. Further, the designated person must indicate the reason(s) why the patient cannot write the request, and it must be drafted in the presence of the physician who is named in the document. The patient can revoke the written request for euthanasia at any time and the document is then removed from the patient's medical record and returned to the patient.

#### *Requirements to be met by the physician*

Section 3 (Article 2) of the Act also lays out conditions that the physician must meet. The patient must be informed of his/her health condition, life expectancy and the physician must discuss the request for euthanasia with the patient. After this discussion, both the patient and the physician must reach the view

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<sup>12</sup> Reginald Deschepper, Wim Distelmans and Johan Bilsen, 'Requests for Euthanasia/Physician-Assisted Suicide on the basis of Mental Suffering: Vulnerable Patients or Vulnerable Physicians?' (2014) 71 (6) *JAMA Psychiatry* 617,617.

that there is no reasonable alternative to the patient's situation and that the patient's request is completely voluntary. The physician must also be certain that the patient is in a state of constant physical or mental suffering, and of the durable nature of the request for euthanasia, by having several conversations with the patient over a reasonable period of time, and taking into account the progress of the patient's condition.

The section goes on to state that the attending physician must consult with an independent physician (independent of the attending physician and also not be otherwise treating the patient) about the serious and incurable disorder that the patient is suffering from. To do so, the independent physician must review the patient's medical records and examine the patient. They too must be certain of the patient's constant and unbearable physical or mental suffering that cannot be alleviated. Additionally, the nursing team (if there is one that has regular contact with the patient) should be consulted and if the patients desires, his/her relatives should also be consulted.

Where the physician believes that the patient is clearly not expected to die in the near future, a second physician, who is a psychiatrist or specialises in the disorder in question, must also be consulted through the process noted above. This physician must be independent of the other physicians involved as well as not be otherwise treating the patient. In these non-terminal cases, the physician must also allow at least one month between the patient's request and the act of euthanasia.

#### *Advance Directives*

Section 4 of the Act also regulates advance requests for euthanasia made by an adult or emancipated minor patient. In order for the physician to perform euthanasia without committing a criminal offence the physician must ensure that the patient suffers from a serious and incurable disorder caused by illness or accident. Further the patient must be no longer conscious, hence in a state of coma, and the coma is irreversible given the current state of medical science. The attending physician must also consult an independent physician about the irreversibility of the patient's condition. That independent physician must review the patient's medical record and examine the patient before reporting his or her findings. Additionally, the nursing team (if it has regular contact with the patient) and any designated 'person in confidence' to the advance directive must be consulted about the patient's euthanasia request. Although the legislation permits advance euthanasia requests, this option is not often exercised in Belgium.<sup>13</sup>

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<sup>13</sup> During the first five years of the Belgian Act on Euthanasia coming into force only 2.1% euthanasia requests were based on an advanced euthanasia directive. See especially, Mette L Rurup, 'The first five years of euthanasia legislation in Belgium and the Netherlands: Description and comparison cases' (2011) 26 (1) *Palliative Medicine* 43, 45. More recently, Kenneth Chambaere et al noted that in 2013 there were 5.5% euthanasia requests based on an advance euthanasia directive. See, Kenneth Chambaere et al, 'Recent trends in euthanasia and other end-of-life practices in Belgium (Supplementary Index)' (2015) 372 (12) *New England Journal of Medicine* 1179-1181.

## *Oversight by the Federal Control and Evaluation Commission (FCEC)*

Section 5 of the Act specifies that any physician who has performed euthanasia must complete a registration form drawn up by the Federal Control and Evaluation Commission (FCEC)<sup>14</sup> and deliver the form to the FCEC within four working days. Section 7 of the Act details the two part registration form that must be completed by the physician.

The first part of the form must be placed under seal by the physician and can only be consulted by the FCEC after a formal decision to do so has been made (see below). Part 1 of the form includes; the patient's full name and address, the health insurance institute registrations numbers of the attending physician and all other physicians consulted about the euthanasia request and the full name, addresses and capacity of person(s) consulted by the attending physician. Further, if the performed euthanasia was by virtue of an advance directive the full names and addresses of the designated 'persons of confidence' must be supplied.

The second part of the registration form also remains confidential and contains more specific details about the patient including: sex, date of birth, place of birth, date and place of death, the nature of the serious and incurable disorder and constant and unbearable pain suffered. Further, the second part of the form also details: the reasons why the pain could not be alleviated; elements underlying the assurance that the request was voluntary, well considered and without external pressure; whether it was expected that the patient would die in the foreseeable future; whether an advanced directive had been drafted; the procedure the physician followed; the capacity of the physician(s) consulted, the recommendations and information from those consultations; the capacity of the persons consulted by the physician and the dates of those consultations; and finally, the manner in which the euthanasia was performed and the pharmaceuticals used.

It is on the basis of the information detailed in the second part of the registration form that the FCEC determines whether the euthanasia was performed in accordance with the conditions of the Act (section 8). Where the FCEC is in doubt about the physician compliance with the Act, with a simple majority, they can revoke the anonymity of the attending physician who performed the euthanasia and examine the first part of the registration form. In that case, the physician will be invited for a hearing at the FCEC. If a two-third majority of the FCEC is of the opinion the physician has not complied with the conditions laid down in the Act, the case is directed to the public prosecutor in the jurisdiction where the euthanasia was performed. To date, there have been no criminal prosecutions of physicians who have performed

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<sup>14</sup> The FCEC is composed of multi-disciplinary members (physicians, lawyers and members of groups for incurably ill patients). Section 6 of the Act details the composition of the FCEC in greater detail and states that it establishes its own internal regulations.

euthanasia in Belgium, although a case was recently referred to the public prosecutor over concerns that the process set out above may not have been followed.<sup>15</sup>

Section 9 of the Act states that the FCEC will draw up reports for the benefit of the legislative chamber within a two year period of the Act coming into force and every two years thereafter detailing: a statistical report processing the information from the second part of the completed physician registration forms; a report evaluating and indicating the application of the law; and, if required, recommendations about new legislation or other measures concerning the execution of the Act.

### **3. Recent Media-Publicised Belgian Developments**

#### *Methodology*

As noted above, this article considers developments in Belgium that have become focal points for Australian media coverage of the assisted dying debate. To identify which developments should be included, searches were undertaken, and updated as at 1 August 2015, of two major media databases: Newsbank<sup>16</sup> and Factiva.<sup>17</sup> Search terms for news media stories included ‘euthanasia’, ‘assisted suicide’, ‘dying with dignity’ and ‘Belgium’/‘Belgian’. Searches parameters were limited so as to only include those cases discussed in the Australian media. The threshold established for when developments were regarded as sufficiently covered by the media to shape the Australian debate was five or more media stories. Where a development meeting these criteria was identified, other more targeted searches using these databases and the internet were undertaken so as to understand that development as much as possible from information in the public domain. One specific limitation noted here is that media reports will necessarily not provide a complete account of the relevant development and the physicians’ deliberations in granting access to the regime. In particular, we note that the media reports on particular cases of euthanasia have tended to focus on the subjective criterion about suffering (and particularly mental suffering) and have not engaged with (or mentioned at all) the objective criterion, namely that the suffering must result from ‘a serious and incurable disorder caused by illness or accident.’

We describe below the four Belgian developments identified through this methodology: the cases of the Verbessem twins, Nathan Verhelst and Frank Van Den Bleeken, and the extension of the Belgian law to permit access to euthanasia by children.<sup>18</sup>

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<sup>15</sup> This is the case of Simona de Moor and is discussed below at n 20.

<sup>16</sup> <http://www.newsbank.com/>

<sup>17</sup> <http://new.dowjones.com/products/factiva/>.

<sup>18</sup> We note that we are aware of four other Belgian euthanasia cases that have received recent publicity and media attention on internet blogs and overseas news media as well as limited Australian coverage. However, these cases were not identified in our methodology and so have

Identical twins Marc and Eddy Verbessem, who were born deaf, were euthanised under the Belgian legislation at the end of 2012 aged 45. The brothers never married, had lived together their entire adult lives and worked as cobblers in the Belgian village of Putte. Their decision to be euthanised came after the discovery of a congenital form of glaucoma that would lead to complete blindness.<sup>19</sup> As the twins could only communicate with one another and their immediate family using sign language,<sup>20</sup> they feared that the impending blindness would lead to complete dependence, being institutionalised and they stated that they ‘had nothing to live for’. Their sibling Dirk Verbessem went on to say that, ‘their great fear was that they would no longer be able to see each other. That was for my brothers unbearable’.<sup>21</sup> He further added, ‘many will wonder why my brothers have opted for euthanasia because there are plenty of deaf and blind that have a “normal life”, but my brothers trudged from one disease to another. They were really worn out’.<sup>22</sup> Marc and Eddy’s local physician also stated that they suffered with other medical problems which included debilitating back pain, making life further ‘unbearable’,<sup>23</sup> presumably referring to the objection criterion of a serious and incurable disorder.

The twin’s initial request for euthanasia was refused by physicians at their local hospital who were of the medical opinion that their deafness and soon blindness did not meet the legislative criteria. One of the physicians stated, ‘there is a law but that is clearly open to various interpretations. If any blind or deaf are

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been excluded although we briefly discuss them here for completeness. ‘Ann G’ was a 44 year old female patient who suffered the mental illness of anorexia nervosa for 25 years. The case received prominence when she accused her treating psychiatrist on national television of sexually abusing her (misconduct by the psychiatrist was later admitted). She eventually sought the assistance of another psychiatrist and requested euthanasia was granted. See, Michael Cook, ‘Another speed bump for Belgian euthanasia’ on *BioEdge: Bioethics news from around the world* (8 Feb 2013) [http://www.bioedge.org/bioethics/another\\_speed\\_bump\\_for\\_belgian\\_euthanasia/10388](http://www.bioedge.org/bioethics/another_speed_bump_for_belgian_euthanasia/10388)>. Godelieva De Troyer was a 64 year old woman suffering with depression who sought euthanasia on the grounds of ‘unbearable suffering’. She did not consult her children about her decision to seek euthanasia and her request was granted. See, Rachel Aviv, ‘The death treatment’ *The New Yorker* (Online) 22 June 2015, <http://www.newyorker.com/magazine/2015/06/22/the-death-treatment>>. ‘Laura’ was a 24 year old woman suffering with suicidal thoughts who recently sought euthanasia. See, Darren Boyle, ‘Belgian doctors give healthy woman, 24, green light to die by euthanasia because of ‘suicidal thoughts’ *The Daily Mail* (Online) 28 June 2015, < <http://www.dailymail.co.uk/news/article-3141564/Belgian-doctors-healthy-woman-green-light-die-euthanasia-suicidal-thoughts.html>>. Most recently, Simona de Moor was a 85 year old woman suffering with depression and sought euthanasia also on the grounds of ‘unbearable psychological suffering’ resulting from the death of her daughter. Simona’s decision to seek euthanasia and the process involved was followed by journalist Brett Mason and aired in a documentary on SBS Dateline. This case is currently being investigated to determine whether the physician performing the euthanasia met all of the necessary conditions. See, SBS, *Belgian euthanasia doctor could face criminal charges* (19 November 2015) < <http://www.sbs.com.au/news/dateline/article/2015/10/29/belgian-euthanasia-doctor-could-face-criminal-charges>>.

<sup>19</sup> Mihaela Frunzã and Sandu Frunzã, ‘Insitutional aspects of the ethical debate on euthanasia: A communicational perspective’ (2013) 12 (34) *Journal for the Study of Religions and Ideologies* 19, 28.

<sup>20</sup> Nancy L Segal, ‘Twin Reunions: The Science Behind the Fascination/Twin Research Reports: Altitude and Hypoxia; Twin Pregnancy Outcomes; Space Mission/Media Highlights: Chinese Twins Reunited; Twin Loss Discovered; Hidden Twins; Twin Euthanasia; Twin Savior’ (2013) 16 (5) *Twin Research and Human Genetics* 1008, 1012.

<sup>21</sup> Bruno Waterfield, Euthanasia twins ‘had nothing to live for’, *The Telegraph* (Online) 14 Jan 2013, <http://www.telegraph.co.uk/news/worldnews/europe/belgium/9801251/Euthanasia-twins-had-nothing-to-live-for.html>.

<sup>22</sup> ‘Marc and Eddy Verbessem, Deaf Belgian Twins, Euthanized after Starting to Turn Blind’, *The Huffington Post* (Online), 14 Jan 2013, < [http://www.huffingtonpost.com/2013/01/14/marc-eddy-verbessem-belgium-euthanasia\\_n\\_2472320.html](http://www.huffingtonpost.com/2013/01/14/marc-eddy-verbessem-belgium-euthanasia_n_2472320.html)>.

<sup>23</sup> Michael Cook, *Six lessons from death in Belgium* (Jan 24 2013) Mercatornet [http://www.mercatornet.com/articles/view/six\\_lessons\\_from\\_death\\_in\\_belgium](http://www.mercatornet.com/articles/view/six_lessons_from_death_in_belgium).



allowed to euthanize [sic], we are far from home. I do not think this was what the legislation meant by “unbearable suffering”.<sup>24</sup>

However, almost two years after their initial request for euthanasia, Professor Wim Distelmans agreed that the twins could be euthanised by lethal injection at Brussels University Hospital. Contrary to the initial objections by physicians, Professor Distelmans asserted, ‘there was certainly unbearable psychological suffering for them. Though there is of course it [is] always possible to stretch the interpretation of that. One doctor will evaluate differently than the other’.<sup>25</sup>

*Nathan Verhelst: 2013*

A 44 year old patient requested euthanasia after being disappointed with the result of female to male gender reassignment surgery. Nathan Verhelst was born female and named Nancy Verhelst. She spent her childhood years in a family that openly spoke of her as an unwanted female child. In an interview with Belgian newspaper, *Het Laatste Nieuws*, Nathan’s mother stated, ‘when I saw “Nancy” for the first time, my dream was shattered...she was so ugly. I had a phantom birth. Her death does not bother me’.<sup>26</sup> In a separate interview, Nathan told the newspaper, ‘I was the girl that nobody wanted, while my brothers were celebrated, I got a storage room above the garage as a bedroom. “If only you had been a boy”, my mother complained. I was tolerated, nothing more’.<sup>27</sup>

In 2009 Nathan underwent hormone therapy, shortly followed by a mastectomy and a penis construction operation in 2012. However, deeply unhappy with the result of the surgeries, Nathan told the Belgian newspaper, ‘I was ready to celebrate my new birth... but when I looked in the mirror, I was disgusted with myself. My new breasts did not match my expectations and my new penis had symptoms of rejection. I do not want to be a monster’.<sup>28</sup>

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<sup>24</sup> Bruno Waterfield, Euthanasia twins ‘had nothing to live for’, *The Telegraph* (Online) 14 Jan 2013, <http://www.telegraph.co.uk/news/worldnews/europe/belgium/9801251/Euthanasia-twins-had-nothing-to-live-for.html>.

<sup>25</sup> Bruno Waterfield, Euthanasia twins ‘had nothing to live for’, *The Telegraph* (Online) 14 Jan 2013, <http://www.telegraph.co.uk/news/worldnews/europe/belgium/9801251/Euthanasia-twins-had-nothing-to-live-for.html>.

<sup>26</sup> Esther Wolfe, ‘Except that the haunted, hidden thing was me: Ghostly matters and transsexual haunting’ (2014) 1 *Ball State University: Digital Literature Review* 1, 41. See also, Bruno Waterfield, ‘Mother of sex change Belgian: ‘I don’t care about his euthanasia death’ *The Telegraph* (Online) 2 Oct 2013, < <http://www.telegraph.co.uk/news/worldnews/europe/belgium/10349159/Mother-of-sex-change-Belgian-I-dont-care-about-his-euthanasia-death.html>>.

<sup>27</sup> Bruno Waterfield, ‘Belgian killed by euthanasia after a botched sex change operation’ *The Telegraph* (Online) 1 Oct 2013, <http://www.telegraph.co.uk/news/worldnews/europe/belgium/10346616/Belgian-killed-by-euthanasia-after-a-botched-sex-change-operation.html>. See also, ‘Belgian man, 44 euthanised on psychological grounds after sex change’ *The Australian* (Online) 2 October 2013 <http://www.theaustralian.com.au/news/world/belgian-man-44-euthanised-on-psychological-grounds-after-sex-change/story-e6frg6so-1226731320677>.

<sup>28</sup> Michael Cook, ‘Belgian euthanased after botched sex-change operation’ on *BioEdge: Bioethics news from around the world* (5 Oct 2013), <[http://www.bioedge.org/bioethics/belgian\\_euthanased\\_after\\_botched\\_sex\\_change\\_operation/10707](http://www.bioedge.org/bioethics/belgian_euthanased_after_botched_sex_change_operation/10707)>.

After several months of counselling and with the agreement of two other physicians, including a psychiatrist, Dr Distelmans, (who also agreed to euthanise Marc and Eddy Verbesssem a year earlier) granted Nathan's request for euthanasia. Film maker, Roel Nollet recorded Nathan's gender transition in a documentary titled, 'Free as a bird' documenting his early surgeries through to his decision to request euthanasia. The video coverage includes interviews with Nathan, his friends and shows him packing his belongings and leaving his apartment and heading to the hospital. Another local television crew filmed his final goodbye and Dr Distelmans giving him the lethal injection that ended his life.<sup>29</sup>

#### *Frank Van Den Bleeken: 2014*

This case concerns a 51 year old Belgian prisoner, Frank Van Den Bleeken. At the age of 21 he was convicted of raping and murdering a 19 year old woman.<sup>30</sup> At his trial he was found not to be criminally responsible and was incarcerated for 7 years in a psychiatric facility.<sup>31</sup> Within weeks of his release from the facility he raped two girls aged 11 and 17 and a woman aged 29, after which Frank was sentenced to a life in prison. In media interviews Frank has claimed that due to his inability to control his violent sexual urges and he has openly admitted that he has no chance of rehabilitation or prospect of being released back into the community.<sup>32</sup>

After complaining about the lack of mental health therapy available to him during his almost 30 year imprisonment, he first requested euthanasia in 2011 on grounds of 'unbearable psychological anguish'.<sup>33</sup> That request was denied, according to media reports, because 'every possible treatment option' had not yet been considered. During an interview that aired on television in 2013, Van Den Bleeken said, 'I'm in my cell 24 hours a day. That's my life. I don't feel human here. What do I have to do? Do I have to sit here and waste away? What's the point in that?'<sup>34</sup>

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<sup>29</sup> Links to the video titled, 'Nathan: Free as a bird' can be found on the internet. It has been noted that Nathan donated his body to medical science. In an interview with the National Post in Canada, Nathan Verhelst's friend Dora Pauwels, who also had gender reassignment surgery, told the newspaper that she would exercise her choice and request euthanasia if her depression and psychosis returned in the future. See especially, Graeme Hamilton, 'Terminally transsexual: Concerns raised over Belgian euthanized after botched sex change' *The National Post* (Online), 22 November 2013, < <http://news.nationalpost.com/news/canada/terminally-transsexual-concerns-raised-over-belgian-euthanized-after-botched-sex-change>>.

<sup>30</sup> Dara Mohammadi, 'European euthanasia laws: Questions of compassion' (2014) 15 (12) *The Lancet Oncology* 1294, 1294.

<sup>31</sup> Michael Cook, 'This man will die from a lethal injection where they do it best' on *Mercatornet*, 22 September 2014, <<http://www.mercatornet.com/careful/view/14830>>.

<sup>32</sup> Nick Miller, 'A life released by euthanasia', *The Sydney Morning Herald* (Online), 28 September 2014, <<http://www.smh.com.au/world/a-life-released-by-euthanasia-20140927-10mh1w.html>>.

<sup>33</sup> 'Belgium to allow jailed murderer Frank Van Den Bleeken to end his own life' *The Sydney Morning Herald* (Online), 16 September 2014, <<http://www.smh.com.au/world/belgium-to-allow-jailed-murderer-frank-van-den-bleeken-to-end-his-own-life-20140915-10hemv.html>>.

<sup>34</sup> Lizzie Dearden, 'Belgian rapist and murderer Frank Van den Bleeken denied request to die in prison', *The Independent* (Online), 6 January 2015, <<http://www.independent.co.uk/news/world/europe/belgian-rapist-and-murderer-frank-van-den-bleeken-denied-request-to-die-in-prison-9961262.html>>.

After a three year petition, his request for euthanasia was initially granted by physicians in late 2014 and the lethal injection was set to be administered in early January 2015. However, less than a week before Van Den Bleeken was to receive the injection the physicians who were to perform the euthanasia revoked the application. A statement made by the Justice Ministry said, ‘medical confidentiality’ prevented the physicians, whom it did not identify, from disclosing why they had decided to stop the process.<sup>35</sup> However, the spokeswoman for the Ministry went on to add that the revocation did not prevent the prisoner from making further requests for euthanasia. Van Den Bleeken has since been moved to a psychiatric treatment centre in the Belgian city of Ghent.<sup>36</sup>

### *Belgian Act on Euthanasia extended to children: 2014*

In December 2013 the Belgian Senate voted in favour of amending the 2002 *Belgian Act on Euthanasia* to extend its remit to include children of all ages. Some months later in February 2014 the Belgian Chamber of Representatives by a majority of 86-44 with 12 abstentions passed the amendments. While the extension of the legislation makes Belgium the only country in the world that does not specify an age restriction for euthanasia the additional specific criteria that must be met are considerably more restrictive than those for adult requests for euthanasia.<sup>37</sup>

First, the minor must have the ‘capacity of discernment’, that is, he or she must be able to demonstrate an understanding of the absolute consequences of such a request.<sup>38</sup> The minor must be suffering from ‘a medically futile condition of constant and unbearable physical suffering that cannot be alleviated and that will result in death in the short term, and that results from a serious and incurable disorder caused by illness or accident’. The minor’s decision to seek assistance to die must be agreed to by their ‘legal representatives’ (generally the minor’s parents). The physician assisting the minor must also consult a child psychiatrist or psychologist to discuss the case. That psychiatrist or psychologist needs to undertake a range of steps including examining the minor and verifying his or her capacity. The outcome of this

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<sup>35</sup> Reuters, *Doctors block Belgian murderer's euthanasia* (6 January 2015) <<http://www.reuters.com/article/2015/01/06/us-belgium-euthanasia-prisoner-idUSKBN0KF1HA20150106>>.

<sup>36</sup> Mary Gearin, *Belgian murderer Frank Van Den Bleeken refused right to medically-assisted suicide* (7 January 2015) ABC News <http://www.abc.net.au/news/2015-01-07/belgian-murderer-refused-medically-assisted-suicide-euthanasia/6003720>.

<sup>37</sup> The Netherlands is the only other country that allows access to euthanasia to children aged 12-16 years with parental consent. Recently, the Dutch Paediatric Association have called for a commission to be established to consider removing the 12 year old age limit and for euthanasia requests to be assessed on a case by case basis. See, ‘Dutch paediatricians: give terminally ill children under 12 the right to die’, *The Guardian* (Online), 19 June 2015, <<http://www.theguardian.com/society/2015/jun/19/terminally-ill-children-right-to-die-euthanasia-netherlands>>.

<sup>38</sup> There is no official English translation available of the recent Belgian amendments relating to children. The examination of the law here is based on this unauthorised version: Christian Munthe, ‘Legalised Euthanasia for Children Regardless of Age in Belgium: The Actual Law in English’, *Philosophical Comment*, 28 August 2015, <<http://philosophicalcomment.blogspot.com.au/2014/02/legalised-euthanasia-for-children.html>>.

consultation also needs to be shared with the minor and his or her legal representatives as part of their decision-making process.

The Belgian Constitutional Court has just considered a challenge to the law governing euthanasia for children. Details of the Court's decision are not yet available in English but media reports note that the challenge to the law was unsuccessful and that the Court concluded that the law had sufficient safeguards to assess children's competency.<sup>39</sup> Of note was a reported finding that the role of the child psychiatrist or psychologist in assessing capacity was not advisory but rather binding on the treating physician.

### *Some observations*

Before considering the impact of these developments in Australia, we pause to consider the nature of these Belgian experiences, and most notably the three cases where euthanasia was granted (albeit in one case later revoked). The first feature of these cases is to note that they involve dimensions that allow for sensationalist media coverage, perhaps explaining why they may have been of such interest. For example, stories about a serial rapist and a person who experienced a failed gender reassignment are capable of being reported on in this way and this is reflected in the headlines used to cover these cases: 'Belgian serial rapist will not be euthanised'<sup>40</sup> and 'Belgian killed by euthanasia after a botched sex change operation'.<sup>41</sup>

There are also two other aspects of these cases that are likely to have prompted wider interest and discussion: none of the individuals who requested euthanasia were terminally ill and all requests were made in relation to the subjective suffering criterion based on mental suffering. Even advocates of euthanasia in Belgium note that permitting access to euthanasia where the sole type of suffering is mental suffering is 'controversial'.<sup>42</sup> And many countries that have either allowed assisted dying or are contemplating doing so are only discussing this in the context of a person with a terminal illness.<sup>43</sup> One

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<sup>39</sup> Alan Hope, 'Constitutional Court upholds euthanasia for minors', *Flanders Today* (Online), 24 November 2015, <<http://www.flandertoday.eu/politics/constitutional-court-upholds-euthanasia-minors>>.

<sup>40</sup> Bruno Waterfield and Andrew Marzal, 'Belgian serial rapist will not be euthanised', *The Telegraph* (Online), 6 January 2015, <<http://www.telegraph.co.uk/news/worldnews/europe/belgium/11327541/Belgian-serial-rapist-will-not-be-euthanised-as-planned.html>>.

<sup>41</sup> Bruno Waterfield, 'Belgian killed by euthanasia after a botched sex change operation' *The Telegraph* (Online) 1 Oct 2013, <http://www.telegraph.co.uk/news/worldnews/europe/belgium/10346616/Belgian-killed-by-euthanasia-after-a-botched-sex-change-operation.html>.

<sup>42</sup> Reginald Deschepper, Wim Distelmans and Johan Bilsen, 'Requests for Euthanasia/Physician-Assisted Suicide on the Basis of Mental Suffering Vulnerable Patients or Vulnerable Physicians?' (2014) 71 (6) *JAMA Psychiatry* 617-618.

<sup>43</sup> One example of this is Oregon, USA, where the law only permits assisted dying where the patient is suffering a terminal illness.

rationale for this is that the person with a terminal illness is inevitably dying so the question for some is one of timing of death rather than causing it.<sup>44</sup>

#### **4. What are the possible implications of these cases for the debate on euthanasia in Australia?**

The Belgian developments discussed above have been the subject of media and other coverage in Australia. So what possible implications might these developments have for how the issue of assisted dying is considered in Australia?

##### *The current debate*

An initial observation is that at least some of these issues raised in Belgium are not part of the debate and discussion that is currently occurring in Australia. The best illustration of this is in relation to euthanasia for children. A recent comprehensive analysis of all attempts to change the law in this area identified 50 bills seeking reform that were brought before Australian State, Territory and Federal Parliaments over the last two decades.<sup>45</sup> All such bills have been limited to assisted dying for competent adults; none have contemplated euthanasia for children, whether Gillick competent or not.

Similar, although less categorical, observations can be made about permitting assisted dying for people who are not terminally ill and seek assistance to die because of mental suffering. Again drawing on the recent analysis of reform attempts, the situations contemplated in the three Belgian cases would not have been permitted under the majority of the euthanasia bills proposing reform models that have gone before Australian Parliaments either because of a terminal illness requirement or because bills were limited in terms of the nature of suffering required and would not extend to mental suffering alone.<sup>46</sup>

So at this point, the sorts of questions that these Belgian developments give rise to are not ones that Australia is either grappling with at all (children), or not are part of the primary reform model that is generally being advanced (cases outside terminal illness and for mental suffering alone). But we specifically say ‘at this point’ because one way in which Belgian developments have been used by opponents of assisted dying is to point to them as evidence of a ‘slippery slope’. Limited legal recognition of assisted dying is just the beginning, so the argument goes, and the sorts of concerning

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<sup>44</sup> See, Martin Gunderson and David J Mayo, ‘Restricting Physician-Assisted Death to the Terminally Ill’ (2000) 30 (6) 17- 23 *The Hastings Center Report* <DOI: 10.2307/3528448>; Sharon I Fraser and James W Walters, ‘Death - whose decision? Euthanasia and the terminally ill’ (2000) 26 (2) *Journal of Medical Ethics* 121-125.

<sup>45</sup> Lindy Willmott, Ben White, Christopher Stackpoole, Kelly Purser, Andrew McGee, ‘(Failed) voluntary euthanasia law reform in Australia: Two decades of trends, models and politics’ (2015) *University of New South Wales Law Journal* (forthcoming).

<sup>46</sup> Lindy Willmott, Ben White, Christopher Stackpoole, Kelly Purser, Andrew McGee, ‘(Failed) voluntary euthanasia law reform in Australia: Two decades of trends, models and politics’ (2015) *University of New South Wales Law Journal* (forthcoming).

cases that we see in Belgium are what we will see in Australia next. It is worth pausing to unpack some more the nature of possible slippery slope arguments that may be mounted because there are generally two distinct arguments (or variations of them): one is an argument about the inevitable expansion of criteria and the other relates to a failure of supposed safeguards to work.<sup>47</sup> We will use this terminology for the remainder of the paper to make clear what we are talking about.

### *Inevitable expansion of criteria*

This argument, sometimes called the ‘logical slippery slope’, states that while Parliament may initially permit assisted dying only for a limited cohort of people (for example, terminally ill adults in unbearable pain), once this becomes socially accepted, the law will slowly but surely expand to allow other wider and undesirable access to assisted dying.<sup>48</sup> This argument could be made in relation to cases where a person is not terminally ill and is experiencing only mental suffering. If a terminally ill adult in great physical pain is allowed to die, why should we restrict access to this cohort? This argument has been advanced drawing on the Verbessem twins as a ‘recent dramatic example of the logical slope’s gravitational pull’.<sup>49</sup>

But perhaps it is the Belgian position in relation to children that is most significant for this argument. Belgium began with only very limited access to assisted dying for children (emancipated minors only) but recently extended access to children of any age, albeit subject to specific safeguards as discussed above. Opponent of euthanasia have pointed to this development as concrete evidence of a slippery slope both in the academic literature<sup>50</sup> and in other forums such as the media and blogs.<sup>51</sup> If Australia permitted assisted dying for competent adults, the argument goes, children would soon have access too.

### *Safeguards do not work in practice*

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<sup>47</sup> See, J Pereira, ‘Legalizing euthanasia or assisted suicide: the illusion of safeguards and controls’ (2011) 18 (2) *Current Oncology* 38-45. For an opposing response to Pereira see, J Downie, K Chambaere and J L Bernheim, ‘Pereira’s attack on legalizing euthanasia or assisted suicide: smoke and mirrors’ (2012) 19 (3) *Current Oncology* 133-138. See also, R Cohen-Almagor, ‘Belgian euthanasia law: a critical analysis’ (2007) 35 (7) *Journal of Medical Ethics* 436-439.

<sup>48</sup> J Donald Boudreau and Margaret A Somerville, ‘Euthanasia is not medical treatment’ (2013) 106 *British Medical Bulletin* 45, 54.

<sup>49</sup> J Donald Boudreau and Margaret A Somerville, ‘Euthanasia is not medical treatment’ (2013) 106 *British Medical Bulletin* 45, 57.

<sup>50</sup> J Donald Boudreau and Margaret A Somerville, ‘Euthanasia is not medical treatment’ (2013) 106 *British Medical Bulletin* 45-66; Tom Mortier et al., ‘Between Palliative Care and Euthanasia’ (2015) *Journal of Bioethical Inquiry* 177-178 < DOI 10.1007/s11673-015-9635-7>. The use of this argument by opponents to assisted dying is also noted by others, see, Jo Samantha, ‘Children and euthanasia: Belgium’s controversial new law’ (2015) 12 (1) *Diversity and Equality in Health and Care* 4-5; Stephen S Hanson, ‘Pediatric Euthanasia and Palliative Care can work Together’ (February 2015) *American Journal of Hospice & Palliative Medicine* 1-4 < doi: 10.1177/1049909115570999>; Bernard Dan et al., ‘Self-requested euthanasia for children in Belgium’ (2014) 383 (9918) *The Lancet* 671-672.

<sup>51</sup> For example, see, Paul Russell, ‘Belgium child euthanasia-fallout and failings’ on *No Euthanasia* (19 February 2014) <http://blog.no euthanasia.org.au/2014/02/belgium-child-euthanasia-fallout-and.html>; Rita Panahi, ‘Euthanasia – the slippery slope’, *Herald Sun* (Online), 15 February 2014, < [http://blogs.news.com.au/heraldsun/missjudgement/index.php/heraldsun/comments/euthanasia\\_for\\_children/](http://blogs.news.com.au/heraldsun/missjudgement/index.php/heraldsun/comments/euthanasia_for_children/)>; Nathan Gamester, *Euthanasia: The slippery slope is real* (21 March 2014) < <https://nathangamester.wordpress.com/2014/03/21/euthanasia-the-slippery-slope-is-real/>>.



The other main ‘slippery slope’ argument, sometimes called the ‘practical’ slope argument, that has been advanced in relation to the Belgian experience is that the three cases where euthanasia was granted or initially granted demonstrate that despite efforts to embed safeguards to ensure that the legislation is only utilised by eligible applicants, and that the vulnerable are protected, the law has not been effective in achieving this.<sup>52</sup> For example, the Van Den Bleeken case has been characterised by many as a failure to provide adequate mental health care<sup>53</sup> and if so, the argument is that this demonstrates the safeguards are not working for this prisoner to initially be granted access to euthanasia.<sup>54</sup> Doubts have also been raised about the Verhelst case and about whether that situation constituted unbearable suffering as required by the legislation. A leading Belgian researcher has described this case in an Australian media interview as being ‘on the borderline of what is possible in the present euthanasia law’.<sup>55</sup> Similar questions have been raised as to how the Verbessem twins could have satisfied the relevant Belgian criteria for euthanasia. One possible reason for doubts surrounding unbearable mental suffering as a criterion for euthanasia may be that unlike physical suffering, it is ‘often less visible and more difficult to fully empathize with’.<sup>56</sup> Further, requests for euthanasia as a result of unbearable mental suffering may be considered to be more invasive and a rapid transition to death by means of euthanasia.<sup>57</sup>

## 5. A proposed response for Australia

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<sup>52</sup> J Donald Boudreau and Margaret A Somerville, ‘Euthanasia is not medical treatment’ (2013) 106 *British Medical Bulletin* 45-66. See also, Alex Schadenberg, ‘Belgian rapist demands euthanasia for psychological pain’ on *Hope: Preventing euthanasia and assisted suicide* (3 January 2014) <<http://www.no euthanasia.org.au/blog/1870-belgian-rapist-demands-euthanasia-for-psychological-pain.html>>. We note that this practical slippery slope argument also has various strands to it. For example, some extend this argument and claim that this then leads to vulnerable individuals feeling pressured into choosing death, see, ‘Euthanasia in Belgium: Safeguards and controls do not work’ on *Alex Schadenberg: Euthanasia prevention collation* (8 December 2013) <<http://alexschadenberg.blogspot.com.au/2013/12/euthanasia-in-belgium-safeguards-and.html>>. Another aspect of this argument relates to the inherent ambiguity in terms such as unbearable suffering to point out that is not possible to devise legislative safeguards that can properly function. For a discussion about what constitutes ‘unbearable suffering’ for patients that have requested euthanasia, see, Marianne K Dees et al., ‘Unbearable suffering’: a qualitative study on the perspectives of patients who request assistance in dying’ (2011) 37 (12) *Journal of Medical Ethics* 727-734; Marianne Dees et al., ‘Unbearable suffering of patients with a request for euthanasia or physician-assisted suicide: an integrative review’ (2010) 19 (4) *Psycho-Oncology* 339-352 < DOI: 10.1002/pon.1612>.

<sup>53</sup> Auke Willems, ‘Euthanasia of detainee: Granting a prisoners request’ (2015) 99(1) *Criminal Justice Matters* 16-17 <<http://www.tandfonline.com/action/showCitFormats?doi=10.1080/09627251.2015.1026563>>.

<sup>54</sup> Of note is that Distelmans (who is an advocate for euthanasia and the treating physician in the euthanasia cases concerning the Verbessem twins and the gender reassignment patient) disagreed with this decision, stating that Frank Van Den Bleeken had not exhausted all possible treatment options before requesting euthanasia. See especially, Dara Mohammadi, ‘European euthanasia laws: Questions of compassion’ (2014) 15 (12) *The Lancet Oncology* 1294-1295 <[http://dx.doi.org/10.1016/S1470-2045\(14\)70476-0](http://dx.doi.org/10.1016/S1470-2045(14)70476-0)>.

<sup>55</sup> Kenneth Chambaere interviewed in Anita Barraud, ‘Euthanasia for children in Belgium’, *Law Report*, 18 February 2014 <http://www.abc.net.au/radionational/programs/lawreport/belgium-child-euthanasia-laws/5264294#transcript>. See also, Eline Gordst, ‘Nathan Verhelst Chooses Euthanasia after Failed Gender Reassignment Surgeries’ *Washington Post* (Online), 10 May 2013, <[http://www.huffingtonpost.com/2013/10/05/nathan-verhelst-euthanasia-belgium\\_n\\_4046106.html](http://www.huffingtonpost.com/2013/10/05/nathan-verhelst-euthanasia-belgium_n_4046106.html)>. For an Australian Parliamentary discussion about the practice of euthanasia in Belgium and some of the case developments discussed in this article, see, Western Australia, Parliamentary Debates, Council, 10 April 2014, (Hon Nick Goiran; Hon Sue Ellery; Hon Liz Behjat; Hon Robin Chapple; Hon Peter Katsambanis; Hon Rick Mazza and Hon Donna Faragher).

<sup>56</sup> Charlotte Verpoort, Chris Gastmans and Bernadette Dierckx de Casterle, ‘Palliative care nurses views on euthanasia’ (2004) 47 (6) *Journal of Advanced Nursing* 592, 595.

<sup>57</sup> Charlotte Verpoort, Chris Gastmans and Bernadette Dierckx de Casterle, ‘Palliative care nurses views on euthanasia’ (2004) 47 (6) *Journal of Advanced Nursing* 592, 595.

In this section, we propose an approach for Australian legislators, policy-makers and the wider community for how these Belgian developments should be understood and used in local deliberations and debate. This includes a critical examination of some of the current discussion to date.

*We should examine and understand the Belgian experience*

It is a basic principle of comparative law that an important part of considering law reform proposals is to examine the law and practice in other jurisdictions that have such laws.<sup>58</sup> Doing so provides an opportunity to understand what is working well and what is not, as well as understanding the context of a particular jurisdiction and how applicable its laws would be to Australia. The fact that assisted dying is a controversial area does not displace this principle. As such, Australia should be examining the Belgian situation, including the developments discussed in this paper, very closely. While key variables such as culture and society may be different, there is undoubtedly much to learn from the law and practice with countries which have taken the step that various Australian Parliaments are considering. Belgium now has well over a decade experience with law in this area and similar arguments can be made in relation to other jurisdictions such as the Netherlands and Oregon.

An important point to make about this is that this consideration of the law in Belgium must be accurate and rational. An example of where public discussion and media coverage failed to achieve this has been in relation to the extension of the law to children. Despite headlines such as ‘Belgium extends euthanasia law to give ill children of any age right to die’,<sup>59</sup> ‘Belgian law on euthanasia for children, with no age limit, will be first in world’<sup>60</sup> and ‘Legal Euthanasia for Children in Belgium: Will It Trigger Death Tourism?’,<sup>61</sup> the law is narrow and access is proscribed to a more limited situation than for adults. Most importantly, access is limited to children who are capable of discernment (what we could call ‘Gillick competence’ in Australia<sup>62</sup>). This is a high threshold, particularly given the nature of the decision, and would only be met in limited circumstances. A number of commentators have made this point that the law will likely only provide access to euthanasia for a very small number of older, mature children,<sup>63</sup>

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<sup>58</sup> See for example, Jeremy Waldon, *Partly Laws Common to All Mankind: Foreign Law in American Courts* (Yale University Press, 2012).

<sup>59</sup> ‘Belgium extends euthanasia law to give ill children of any age right to die’, *The Australian* (Online), 14 February 2014, <<http://www.theaustralian.com.au/news/world/belgium-extends-euthanasia-law-to-give-ill-children-of-any-age-right-to-die/story-e6frg6so-1226826805067>>.

<sup>60</sup> Ian Traynor, ‘Belgian law on euthanasia for children, with no age limit, will be first in world’, *The Guardian* (Online), 13 February 2014, <http://www.theguardian.com/world/2014/feb/12/belgium-legalise-euthanasia-children-age-limit>.

<sup>61</sup> Cecilia Rodriguez, ‘Legal Euthanasia for Children in Belgium: Will It Trigger Death Tourism?’ *Forbes* (Online) 7 March 2014, <http://www.forbes.com/sites/ceciliarodriguez/2014/03/06/2378/>.

<sup>62</sup> Ben Mathews, ‘Children and Consent to Medical Treatment’ in Ben White, Fiona McDonald and Lindy Willmott (eds), *Health Law in Australia* (Thomson, 2nd ed, 2014).

<sup>63</sup> See, Jo Samantha, ‘Children and euthanasia: Belgium’s controversial new law’ (2015) 12 (1) *Diversity and Equality in Health and Care* 4-5; Bernard Dan et al., ‘Self-requested euthanasia for children in Belgium’ (2014) 383 (9918) *The Lancet* 671-672.



particularly in light of the very limited use of the law by young people prior to this change with only four seeking euthanasia since the law started in 2002 and none of them had been minors.<sup>64</sup> Yet this was very different from how the change in law was reported in many quarters.<sup>65</sup>

The need for accuracy arises not only in relation to stating the law but also in understanding how that law is practised. There is now a large peer-reviewed evidence-base on how the Belgian law is functioning (as well as how other permissive jurisdictions are operating as well).<sup>66</sup> As we discuss below, engagement with this research is important to understand some of the concerns raised about the slippery slope. Therefore, in light of our suggested approach, we now turn to the two arguments that critics of the Belgian developments have raised and examine them in light of the evidence and information we have available.

### *Inevitable expansion of criteria*

Recall that opponents of assisted dying pointed to the Belgian experience, particularly the extension of the law to children, to argue that once euthanasia is permitted, the categories of people who will have access to it will inevitably expand in undesirable ways.

It is not possible to demonstrate that a decision by Australian Parliaments today or in the next five years to allow access to assisted dying to terminally ill competent adults would not be extended in the future. This is the nature of such discussions as they call for prediction of the future.<sup>67</sup> And of course, whether the law should change or not is a matter for those Australian Parliaments (informed by their obligations to their constituents) to consider if and when these issues are raised. But it is also equally not possible to demonstrate that a decision to allow initial access to terminally ill competent adults will then extend to other groups as is claimed. While some might point to the experience in Belgium, others might look to places such as Oregon which has over 15 years of experience in assisted dying and has not widened its criteria, for example to allowing euthanasia rather than just physician assisted suicide. So while arguments such as these raise important considerations about the proper current and future scope of such

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<sup>64</sup> Bernard Dan et al., 'Self-requested euthanasia for children in Belgium' (2014) 383 (9918) *The Lancet* 671-672, citing Commission Fédérale de Contrôle et d'Évaluation de l'Euthanasie, *Rapports aux Chambres Législatives 2004–2012* (SPF Santé publique, Sécurité de la Chaîne alimentaire et Environnement, 2013).

<sup>65</sup> Jan L Bernheim et al., 'Questions and Answers on the Belgian Model of Integral End-of-Life Care: Experiment? Prototype?' 2014 11 (4) *Journal of Bioethical Inquiry* 507, 52.

<sup>66</sup> This research is cited throughout this paper and in particular see note 72 below.

<sup>67</sup> U Schüklenk et al., 'End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making' (2011) 25 S1 *Bioethics* 1, 49.

laws, without a clear and compelling evidence base as to what might be likely to happen, they are speculative claims and need to be seen as such.<sup>68</sup>

Indeed, to the extent there is evidence which might help predict the future, it points to significant barriers to widening any assisted dying law that might be introduced in Australia. Apart from a single Act in the Northern Territory, Australian Parliaments have been persistent in their refusal to enact legislation that would legalise voluntary euthanasia and/or assisted suicide. Fifty bills have been put before Parliaments but only one (in the Northern Territory, and for a limited time) has succeeded. This suggests that should assisted dying become lawful in Australia, a cautious and careful approach would be taken to arguments about widening criteria for who can access the scheme. Further, any decision-making about this would invariably be informed by the empirical data that is routinely collected alongside such regimes (assuming such systems were also set up in Australia).

Another key response to this argument is that there are points (or ‘notches’) on the way down the ‘slope’ to carefully consider what has happened to date and whether a change in law is justified. There is a very effective opposition to euthanasia in Australia and it would be instrumental in ensuring any further steps were considered carefully and that important considerations, such as protecting the vulnerable, were taken into account by legislators (as they should be).

Therefore, claims that the Belgian developments demonstrate a slippery slope that Australia would inevitably slide down or follow are speculative. We agree that policy-makers and legislators need to be aware of and take into account the Belgian experience but assertions about future inevitable changes to Australian law should be viewed with scepticism.

### *Safeguards do not work in practice*

Opponents of assisted dying have raised questions about the euthanasia law safeguards in Belgium in light of these cases. We do not feel able to express a definitive view on these cases in the absence of a comprehensive understanding of the medical and other evidence relied upon to offer euthanasia. These full details are not publicly available: as noted, our method has been to identify cases discussed in the Australian media, which we then supplemented with other available commentaries. Nevertheless, there are some observations we make about the claims raised about these cases.

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<sup>68</sup> U Schüklenk et al, ‘End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making’ (2011) 25 S1 Bioethics 1, 49.

Although we acknowledge that there are other cases that are not widely reported in the Australian media (or reported at all) which may raise concerns or questions, we do note that these are only three cases. This point does not seek to diminish the significance of these cases nor the life and death of these individuals who sought assistance to die. But it is important to note that these controversial cases are just three of the 8 776 deaths that have occurred under the Belgian regime since the introduction of the law in 2002 until the end of 2013.<sup>69</sup> Judgments about the effectiveness of the system and its safeguards would need to be assessed having regard to that wider context and not just these three cases which have attracted such attention.<sup>70</sup> As noted, one response to this argument is that the confidential nature of the Belgian system means that there could be more concerning cases that we simply do not know about. It is true that this could be possible but again we find ourselves in the realm of speculation. One piece of evidence that can be noted is the delay in these three cases between the requests for euthanasia and that assistance being granted (sometimes it was years). This perhaps provides some evidence that the safeguards were given careful consideration, particularly given the controversial nature of the cases, before euthanasia occurred.

There is also a substantial body of empirical evidence about how the Belgian system has operated over a thirteen year period. Although there are those who raise concerns about current practice,<sup>71</sup> as a whole, the research concludes there is not evidence of a practical slippery slope in that it finds that the legal safeguards are generally being adhered to and assisted dying is not disproportionately utilised by vulnerable groups.<sup>72</sup> This is consistent with findings in other jurisdictions which have regulated assisted dying regimes.<sup>73</sup>

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<sup>69</sup> Commission Fédérale de Contrôle Et D'évaluation De L'euthanasie, *Sixieme Rapport Aux Chambres Législatives (Années 2012-2013)*, 2014 <<http://www.ieb-eib.org/fr/pdf/rapport-euthanasie-2012-2013.pdf>>. Data for later years is not yet available.

<sup>70</sup> See, Dara Mohammadi, 'European Euthanasia Laws: Questions of Compassion' (2014) 15 (12) *The Lancet Oncology* 1294 – 1295.

<sup>71</sup> See for example, Raphael Cohen-Almagor, 'First do no harm: intentionally shortening lives of patients without their explicit request in Belgium' (2015) *Journal of Medical Ethics* <doi:10.1136/medethics-2014-102387>; Tom Mortier et al., 'Between Palliative Care and Euthanasia' (2015) 12 (2) *Journal of Bioethical Inquiry* 177-178; Raphael Cohen-Almagor, 'First do no harm: pressing concerns regarding euthanasia in Belgium' (2013) 36 (5) *International Journal of Law and Psychiatry* 515-521.

<sup>72</sup> See for example, Tinne Smets, Johan Bilsen, Joachim Cohen, Mette L. Rurup and Luc Deliens, 'Legal Euthanasia in Belgium: Characteristics of All Reported Euthanasia Cases' (2010) 48(2) *Medical Care* 187-192; Kenneth Chambaere, Robert Cander Stichele, Freddy Mortier, Joachim Cohen and Luc Deliens, 'Correspondence – Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium' (2015) 372 *The New England Journal of Medicine* 1179-1181 (although noting an increase in the rate of euthanasia, this research noted a stricter assessment of the relevant legal eligibility criteria); Yanna Van Wesemael, Joachim Cohen, Johan Bilsen, Tinne Smets, Bregje Onwuteaka-Philipsen, and Luc Deliens, 'Process and Outcomes of Euthanasia Requests Under the Belgian Act on Euthanasia: A Nationwide Survey' (2011) 42(5) *Journal of Pain and Symptom Management* 721-733. Note though a qualitative study of 9 general practitioners which found compliance with substantive legal requirements but more limited compliance with procedural requirements: Tinne Smets, Johan Bilsen, Lieve Van den Block, Joachim Cohen, Viviana Van Casteren and Luc Deliens, 'Euthanasia in patients dying at home in Belgium: interview study on adherence to legal safeguards' (2010) 60(673) *The British Journal of General Practice* e163-170.

<sup>73</sup> See for example, Judith A.C. Rietjens, Paul J. van Maas, Bregje D. Onwuteaka-Philipsen, Johannes J.M. van Delden and Anges van der Heide, 'Two Decades of Research on Euthanasia from the Netherlands. What Have we Learnt and What Questions Remain?' (2009) 6(3) *Journal of Bioethical Inquiry* 271-283; Bregje D Onwuteaka-Philipsen, Arianna Brinkman-Stoppelenburg, Corine Penning, Gwen JF de Jong-Krul, Johannes JM van Delden, Agnes van der Heide, 'Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey' (2012) 380(9845) *The Lancet* 908-915; Margaret P Battin, Agnes van der Heide, Linda Ganzini, Gerrit van der Wal and Bregje D Onwuteaka-Philipsen, 'Legal physician-assisted dying in Oregon and the Netherlands: evidence concerning the impact on patients in 'vulnerable' groups' (2007) 33(10) *Journal of Medical Ethics* 591-597; U Schüklenk et al, 'End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making' (2011) 25 S1 *Bioethics* 1, 65.

## **6. Conclusion**

Assisted dying is a topic that inevitably raises polarised views. This is understandable given that the result, by definition, involves a life and death decision. These divergent community views find themselves reflected in media coverage both of the wider assisted dying debates and in coverage of particular cases or developments. This article identified four developments in Belgium which have been the subject of significant media coverage in Australia. Three were cases where a person sought assistance to die and the fourth was the extension of the Belgian law to children provided certain conditions were met.

The purpose of this article was to reflect on the relevance for Australian legislators, policy-makers and the wider community of these Belgian developments, which through that media coverage, have become part of the national discussion on assisted dying. We have argued that these developments are important and need to be considered as part of our policy deliberations. But these deliberations should be based on a careful understanding of the relevant legal framework, the substantial body of empirical evidence about how the regime operates and a rational evaluation of these four developments in that setting. The risk of not doing so, in part fostered by some sensationalised media coverage, is a less than ideal policy position on assisted dying in Australia.